SCIM-SPINAL CORD INDEPENDENCE MEASURE

If form filled out in last 1 year and no changes, Check here ☐

Please clearly circle only one answer for each question.

Self-Care

1. Feeding (cutting, opening containers, pouring, bringing food to mouth, holding cup with fluid)
0. Needs parenteral, gastrostomy, or fully assisted oral feeding
1. Needs partial assistance for eating and/or drinking, or for wearing adaptive devices
2. Eats independently; needs adaptive devices or assistance only for cutting food and/or pouring and/or opening containers
3. Eats and drinks independently; does not require assistance or adaptive devices

2. Bathing (soaping, washing, drying body and head, manipulating water tap). **A-upper body; B-lower body**

A. 0. Requires total assistance
1. Requires partial assistance
2. Washes independently with adaptive devices or in a specific setting (e.g., bars, chair)
3. Washes independently; does not require **a**daptive **d**evices or **s**pecific **s**etting (not customary for healthy people) (adss)

B. 0. Requires total assistance
1. Requires partial assistance
2. Washes independently with **a**daptive **d**evices or in a **s**pecific **s**etting (adss)
3. Washes independently; does not require **a**daptive **d**evices (adss) or **s**pecific **s**etting

3. Dressing (clothes, shoes, permanent orthoses: dressing, wearing, undressing). **A-upper body; B-lower body**

A. 0. Requires total assistance
1. Requires partial assistance with **c**lothes **w**ith**o**ut **b**uttons, **z**ippers or **l**aces (cwobzl)
2. Independent with cwobzl; requires **a**daptive **d**evices and/or **s**pecific **s**ettings (adss)
3. Independent with cwobzl; does not require adss; needs assistance or adss only for bzl
4. Dresses (any cloth) independently; does not require adaptive devices or specific setting

B. 0. Requires total assistance
1. Requires partial assistancewith **c**lothes **w**ith**o**ut **b**uttons, **z**ippers or **l**aces (cwobzl)
2. Independent with cwobzl; requires adaptive devices and/or specific settings (adss)
3. Independent with cwobzl without adss; needs assistance or adss only for bzl
4. Dresses (any cloth) independently; does not require adaptive devices or specific setting

4. Grooming (washing hands and face, brushing teeth, combing hair, shaving, applying makeup)
0. Requires total assistance
1. Requires partial assistance
2. Grooms independently with adaptive devices
3. Grooms independently without adaptive devices

SUBTOTAL (0-20)

Respiration and Sphincter Management

5. **Respiration**

0. Requires tracheal tube (TT) and permanent or intermittent assisted ventilation (IAV)
2. Breathes independently with TT; requires oxygen, much assistance in coughing or TT management
4. Breathes independently with TT; requires little assistance in coughing or TT management
6. Breathes independently without TT; requires oxygen, much assistance in coughing, a mask (e.g., peep) or IAV (bipap)
8. Breathes independently without TT; requires little assistance or stimulation for coughing
10. Breathes independently without assistance or device

6. Sphincter Management - Bladder

0. Indwelling catheter
3. Residual urine volume (RUV) > 100cc; no regular catheterization or assisted intermittent catheterization
6. RUV < 100cc or intermittent self-catheterization; needs assistance for applying drainage instrument
9. Intermittent self-catheterization; uses external drainage instrument; does not need assistance for applying
11. Intermittent self-catheterization; continent between catheterizations; does not use external drainage instrument
13. RUV <100cc; needs only external urine drainage; no assistance is required for drainage
15. RUV <100cc; continent; does not use external drainage instrument

7. Sphincter Management - Bowel

0. Irregular timing or very low frequency (less than once in 3 days) of bowel movements
5. Regular timing, but requires assistance (e.g., for applying suppository); rare accidents (less than twice a month)
8. Regular bowel movements, without assistance; rare accidents (less than twice a month)
10. Regular bowel movements, without assistance; no accidents

8. Use of Toilet (perineal hygiene, adjustment of clothes before/after, use of napkins or diapers).

0. Requires total assistance
1. Requires partial assistance; does not clean self
2. Requires partial assistance; cleans self independently
4. Uses toilet independently in all tasks but needs adaptive devices or special setting (e.g., bars)
5. Uses toilet independently; does not require adaptive devices or special setting**)**

SUBTOTAL (0-40)

Mobility (room and toilet)

9. Mobility in Bed and Action to Prevent Pressure Sores

0. Needs assistance in all activities: turning upper body in bed, turning lower body in bed, sitting up in bed, doing push-ups in wheelchair, with or without adaptive devices, but not with electric aids
2. Performs one of the activities without assistance
4. Performs two or three of the activities without assistance
6. Performs all the bed mobility and pressure release activities independently

10. Transfers: bed-wheelchair (locking wheelchair, lifting footrests, removing and adjusting arm rests, transferring, lifting feet).

0. Requires total assistance
1. Needs partial assistance and/or supervision, and/or adaptive devices (e.g., sliding board)
2. Independent (or does not require wheelchair)

11. Transfers: wheelchair-toilet-tub (if uses toilet wheelchair: transfers to and from; if uses regular wheelchair: locking wheelchair, lifting footrests,removing and adjusting armrests, transferring, lifting feet)

0. Requires total assistance
1. Needs partial assistance and/or supervision, and/or adaptive devices (e.g., grab-bars)
2. Independent (or does not require wheelchair)

Mobility (indoors and outdoors, on even surface)

12. Mobility Indoors

0. Requires total assistance
1. Needs electric wheelchair or partial assistance to operate manual wheelchair
2. Moves independently in manual wheelchair
3. Requires supervision while walking (with or without devices)
4. Walks with a walking frame or crutches (swing)
5. Walks with crutches or two canes (reciprocal walking)
6. Walks with one cane
7. Needs leg orthosis only
8. Walks without walking aids

13. Mobility for Moderate Distances (10-100 meters)

0. Requires total assistance
1. Needs electric wheelchair or partial assistance to operate manual wheelchair
2. Moves independently in manual wheelchair
3. Requires supervision while walking (with or without devices)
4. Walks with a walking frame or crutches (swing)
5. Walks with crutches or two canes (reciprocal walking)
6. Walks with one cane
7. Needs leg orthosis only
8. Walks without walking aids

14. Mobility Outdoors (more than 100 meters)

0. Requires total assistance
1. Needs electric wheelchair or partial assistance to operate manual wheelchair
2. Moves independently in manual wheelchair
3. Requires supervision while walking (with or without devices)
4. Walks with a walking frame or crutches (swing)
5. Walks with crutches or two canes (reciprocal waking)
6. Walks with one cane
7. Needs leg orthosis only
8. Walks without walking aids

15. Stair Management

0. Unable to ascend or descend stairs
1. Ascends and descends at least 3 steps with support or supervision of another person
2. Ascends and descends at least 3 steps with support of handrail and/or crutch or cane
3. Ascends and descends at least 3 steps without any support or supervision

16. Transfers: wheelchair-car (approaching car, locking wheelchair, removing arm and footrests, transferring to and from car, bringing wheelchair into and out of car)

0. Requires total assistance
1. Needs partial assistance and/or supervision and/or adaptive devices
2. Transfers independent; does not require adaptive devices (or does not require wheelchair)

17. Transfers: ground-wheelchair

0. Requires assistance
1. Transfers independent with or without adaptive devices (or does not require wheelchair)

SUBTOTAL (0-40)

SF-8 Health Survey

Please circle only one answer for each question

1. Overall, how would you rate your health in the past 4 weeks?

Excellent	Very good	Good Fair	Poor	Very poor

2. During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

Not at all	Very little	Somewhat	Quite a lot	Could not do physical activities

3. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

None at all	A little bit	Some	Quite a lot	Could not do daily work

4. How much bodily pain have you had in the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe

5. During the past 4 weeks, how much energy did you have?

Very much	Quite a lot	Some	A little	None

6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

Not at all	Very little	Somewhat	Quite a lot	Could not do social activities

7. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

Not at all	Slightly	Moderately	Quite a lot	Extremely

8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

Not at all	Very little	Somewhat	Quite a lot	Could not do daily activities

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Subj #: | | | | | | |

Date: | | / | | / | | |

OU Physicians
UROLOGY CLINIC
Voiding Dys: (SIDI-F)

Patient Name: _____
(Patient name is not stored in the database.)

Please use a pen to fill in the circle/ box(s) to indicate your choice.

Sexual Interest and Desire Inventory - Female (SIDI-F)

INTRODUCTION: The following questions are used to assess your feelings of sexual interest or desire as well as some other aspects of your sex life. By sexual desire, I mean your interest in having a sexual experience whether alone or with a partner. Sexual interest involves thoughts, feelings, and/or a willingness to become involved in some sort of sexual activity.

Please remember that there are no right or wrong answers to the questions asked. I am most interested in what you feel - not what you think you should feel or what you think others feel. If you do not understand any of the questions, please let me know.

The following question asks about your relationship with your partner/spouse.

ITEM 1: RELATIONSHIP - SEXUAL
How Satisfied are you with the sexual aspect of your relationship with your partner?

- ☐ Dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Neutral
- ☐ Somewhat satisfied
- ☐ Satisfied

SEXUAL ACTIVITY
Over the past month, approximately how many times did you engage in sexual activity either alone or with your partner?
By sexual activity, I am referring to sexual caressing, genital stimulation (including masturbation) or intercourse.

- ☐ Never
- ☐ 1-2 times a month
- ☐ 3-4 times a month
- ☐ More than once a week?

ITEM 2: RECEPTIVITY
Over the past month, when your partner approached you for sex, how often did you accept?
When you accepted, what was your level of enthusiasm?

- ☐ Partner never approached for sex
- ☐ No enthusiasm or did not participate

	Participated solely/primarily out of obligation	Participated with some interest, but little sexual enthusiasm	Receptive to partner's approach, interested sexually	Sexually enthusiastic and encouraging
Infrequent (less than half the time)	☐	☐	☐	☐
Often (half the time or more, but not always)	☐	☐	☐	☐
Always	☐	☐	☐	☐

ITEM 3: INITIATION
Over the past month, how frequently did you do anything to encourage sex with your partner?

- ☐ Did not encourage/initiate
- ☐ 1-2 times a month
- ☐ 3-4 times a month
- ☐ More than once a week

*Comments:

_____

Patient Name: _____

(Patient name is not stored in the database.)

ITEM 4: DESIRE - FREQUENCY

Over the past month, how frequently have you wanted to engage in some kind of sexual activity, either with or without a partner?

How strong was your desire to engage in sex?

Please answer this question even if you did not actually engage in any sexual activity but were aware of wanting to be sexual in some way.

☐ Never wanted to have sex	Not intense at all (fleeting)	Mildly intense	Moderately intense	Extremely intense
1-2 times / month	☐	☐	☐	☐
3-4 times / month	☐	☐	☐	☐
More than once a week	☐	☐	☐	☐

ITEM 5: AFFECTION

Over the past month, how often have you wanted physical affection other than sex, for example touching, holding, kissing?

How intense would you say was your desire for physical affection?

☐ Never wanted to have physical affection	Mildly intense	Moderately intense	Extremely intense
Less than once a week	☐	☐	☐
More than once a week but not every day	☐	☐	☐
Daily	☐	☐	☐

ITEM 6: DESIRE - SATISFACTION

Over the past month, how satisfied were you with your overall level of sexual desire/interest?

- ☐ Dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Neutral
- ☐ Somewhat satisfied
- ☐ Satisfied

ITEM 7: DESIRE - DISTRESS

Over the past month, when you thought about sex or were approached for sex, how distressed (worried, concerned, guilty) were you about your level of desire?

- ☐ Never distressed
- ☐ Mildly distressed
- ☐ Moderately distressed
- ☐ Markedly distressed
- ☐ Extremely/Severely distressed

*Comments:

Patient Name: _____

(Patient name is not stored in the database.)

ITEM 8: THOUGHTS - POSITIVE
How often have you thought about sex over the past month?

When you thought about sex, what was your level of interest/strength of desire in having sex?

☐ Never thought about sex	Never associated with desire	Mild desire	Moderate desire	Intense desire
1-2 times / month	☐	☐	☐	☐
3-4 times / month	☐	☐	☐	☐
More than once a week	☐	☐	☐	☐

ITEM 9: EROTICA
Over the past month, how did you react to sexually suggestive material (e.g. love scenes in movies and on television, erotic pictures/stories in magazines/books)?

- ☐ Not interested
- ☐ Mildly interested
- ☐ Moderately interested
- ☐ Highly interested

ITEM 10: AROUSAL - FREQUENCY
Over the past month, how often did you become aroused (sexually excited, wet, lubricated, etc.)?

- ☐ No sexual activity
- ☐ Never become aroused
- ☐ Infrequent (less than half the time)
- ☐ Often (half the time or more, but not always)
- ☐ Always

ITEM 11: AROUSAL EASE
Over the past month, when you had sex, how easily did you become aroused (sexually excited, wet, lubricated, etc.) in response to sexual stimulation?

- ☐ No sexual activity
- ☐ Not at all aroused
- ☐ Aroused with difficulty
- ☐ Aroused somewhat easily
- ☐ Easily aroused

ITEM 12: AROUSAL CONTINUATION
Over the past month, once you started to become sexually aroused, did you want to receive more stimulation? If yes, how strong was your desire to be further/more sexually stimulated?

- ☐ No sexual activity
- ☐ No desire/Never aroused
- ☐ Little desire
- ☐ Moderate desire
- ☐ Strong desire

ITEM 13: ORGASM
Over the past month, when you had sex, how often did you have an orgasm?

How easy was it for you to have an orgasm?

☐ No sexual activity ☐ Not able to achieve orgasm	Achieved majority of orgasms with **some difficulty**	Achieved majority of orgasms **without difficulty**
Infrequent (less than half the time)	☐	☐
Often (half the time or more, but not always)	☐	☐
Always	☐	☐

*Comments: _____

Patient Name: _____

(Patient name is not stored in the database.)

DM ITEM 1: RELATIONSHIP - GENERAL
How satisfied are you with your relationship as a whole?

- ☐ Dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Neutral
- ☐ Somewhat satisfied
- ☐ Satisfied

DM ITEM 2: THOUGHTS - NEGATIVE
Over the past month, including this interview, when you think about having sex, do you feel any of the following negative feelings: turned off, anxious, repulsed, sick?

- ☐ Never turned off/felt negative
- ☐ Somewhat turned off/felt somewhat negative
- ☐ Definetly turned off/Strong negative feeling

DM ITEM 3: PAIN
Over the past month, did you experience genital pain during sex?

- ☐ Yes, and it made me stop
- ☐ Yes, but continued through the pain
- ☐ Yes, but pain was transient
- ☐ No pain
- ☐ No sexual activity

DM ITEM 4: MOOD
Over the past month, how has your mood been?

Have you experienced any feelings of: sadness, hopelessness, helplessness, worthlessness?

How often have you had such feelings?

☐ Absent or clinically insignificant	**Mild** (Feelings of saness, discouragement, low self-esteem, pessimism)	**Moderate** (Clear nonverbal signs of sadness, feelings of hoplessness, helplessness, or worthlessness about some aspects of life)	**Severe** (Intense sadness, hoplessness about most aspects of life, feelings of complete helplessness or worthlessness)	**Very Severe** (Extreme sadness; intractable hoplessness or helplessness)
Infrequent (less than half your waking hours)	☐	☐	☐	☐
Often (half your waking hours or more, but not always)	☐	☐	☐	☐
Alway	☐	☐	☐	☐

DM ITEM 5: FATIGUE
Over the past month, did you experience fatigue, tiredness, or loss of energy?
How often did you experience fatigue, tiredness, or loss of energy?

☐ Absent or clinically insignificant	**Mild** (mild tiredness, loss of enerty, fatigue, feelings of heaviness in limbs or being weighted down)	**Moderate to Marked** (prominent tiredness, loss of energy, fatigue, feelings of heaviness in limbs or being weighted down)
Infrequent (less than half your waking hours)	☐	☐
Often (half your waking hours or more, but not always)	☐	☐
Always	☐	☐

*Comments:

INCONTINENCE QUESTIONAIRE (UDI-6)

Name: _____ Date: _____

DO YOU EXPEREINCE ANY URINARY INCONTINENCE? _____ YES _____ NO

Please circle the number that best describes what you are feeling. Use the following as your guide.

(0) Not at All
(1) Slightly
(2) Moderately
(3) Greatly

Do you experience, and if so, how much are you bothered by:

1. Frequent urination? (0) (1) (2) (3)
2. Urine leakage related to the felling of urgency? (0) (1) (2) (3)
3. Urine leakage related to physical activity, coughing, or sneezing? (0) (1) (2) (3)
4. Small amounts of urine leakage? (0) (1) (2) (3)
5. Difficulty emptying your bladder? (0) (1) (2) (3)
6. Pain or discomfort in the lower abdomen or genital area? (0) (1) (2) (3)

(For physician only)

_____ Timed Voiding

_____ Double Voiding

_____ Conservative Fluid Management

_____ Kegel Exercise Program

_____ Anti-cholinergic or Other Medical Therapy

_____ Urodynamic Evaluation Discussed

_____ Surgical Intervention Discussed

Physician Signature: _____ Date: _____

Incontinence Impact Questionnaire – Short Form IIQ-7

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your:

	Not at All	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity
Item 5 = social/relationships
Items 3 and 4 = travel
Items 6 and 7 = emotional health

Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference. Uebersax, J.S., Wyman, J. F., Shumaker, S. A., McClish, D. K., Fantl, J. A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: The incontinence impact questionnaire and the urogenital distress inventory. Neurourology and Urodynamics, 14, 131-139.

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Subject #: ☐☐☐☐☐☐

DATE: ☐☐ / ☐☐ / ☐☐

OU Physicians
UROLOGY CLINIC
I C I Q

Patient Name: _____
(Patient name is not stored in the database.)

Please use a pen to fill in the circle/ box(s) to indicate your choice.

ICIQ Questionnaire

It is not uncommon for people to leak urine some of the time. Through your responses to this questionnaire, we will be able to collect data on how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, *on average,* over the past four weeks.

1. How often do you leak urine? (Select only one choice.)

☐ 0 Never
☐ 1 About once a week or less
☐ 2 Two or Three times a week
☐ 3 About once a day
☐ 4 Several times a day
☐ 5 All the time

2. How much urine do you think you usually leak?

☐ 0 None
☐ 2 A small amount
☐ 4 A moderate amount
☐ 6 A large amount

3. Overall, how much does leaking urine interfere with your everyday life?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at **A great deal**

ICIQ score:(Sum scores 1+2+3) ☐☐

4. When does urine leak? (Select all that apply)

☐ Never - Urine does not leak
☐ Leaks before you can get to the toilet
☐ Leaks when cough or sneeze
☐ Leaks when you are asleep
☐ Leaks when you are physically active/exercising
☐ Leaks when you have finished urinating and are dressed
☐ Leaks for no obvious reason
☐ Leaks all the time

*Comments:

Pt Initials:_____ Pt ID No.:_____

OAB-q Short Form Symptom Bother

This questionnaire asks about how much you have been bothered by selected bladder symptoms during the past 4 weeks. Please *check the box* that best describes the extent to which you were bothered by each symptom during the past 4 weeks. There are no right or wrong answers. Please be sure to answer every question.

During the past 4 weeks, how bothered were you by. . .	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**A great deal**	**A very great deal**
1. An uncomfortable urge to urinate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. A sudden urge to urinate with little or no warning	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Accidental loss of small amounts of urine	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Nighttime urination	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Waking up at night because you had to urinate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Urine loss associated with a strong desire to urinate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Pt Initials:_____ Pt ID No.:_____

For the following questions, please think about your overall bladder symptoms in the past 4 weeks and how these symptoms have affected your life. Please answer each question about how often you have felt this way to the best of your ability. Please *check the box* that best answers each question.

During the past 4 weeks, how often have your bladder symptoms ...	**None of the time**	**A little of the time**	**Some of the time**	**A good bit of the time**	**Most of the time**	**All of the time**
1. Caused you to plan "escape routes" to toilets in public places?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. Made you feel like there is something wrong with you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Interfered with your ability to get a good night's rest?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Made you frustrated or annoyed about the amount of time you spend in the toilet?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Made you avoid activities away from toilets (i.e., walks, running, hiking)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Awakened you during sleep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
7. Caused you to reduce your physical activities (exercising, sports, etc.)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8. Caused you to have problems with your partner or spouse?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
9. Made you uncomfortable while travelling with others because of needing to stop to go to the toilet?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
10. Affected your relationships with family and friends?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
11. Interfered with getting the amount of sleep you needed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
12. Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
13. Caused you to locate the closest toilet as soon as you arrive at a place you have never been?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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Neurogenic Bowel Dysfunction Score

The number of points for each possible answer is given in parenthesis.
Mark only one answer per question.

1. Frequency of defecation — Points

☐ Daily (0) ☐ 2–6 times every week (1) ☐ Less than once a week (6) ____

2. Time used for each defecation

☐ 0–30 min (0) ☐31–60 min (3) ☐More than one hour (7) ____

3. Uneasiness, headache or perspiration during defecation

☐ No (0) ☐ Yes (2) ____

4. Regular use of tablets against constipation

☐ No (0) ☐ Yes (2) ____

5. Regular use of drops against constipation

☐ No (0) ☐ Yes (2) ____

6. Digital stimulation or evacuation of the anorectum.

☐ Less than once every week (0) ☐ Once or more every week (6) ____

7. Frequency of fecal incontinence.

☐ Less than once every month (0) ☐ 1–4 times every month (6)
☐ 1–6 times every week (7) ☐ Daily (13) ____

8. Medication against fecal incontinence.

☐ No (0) ☐ Yes (4) ____

9. Flatus incontinence.

☐ No (0) ☐ Yes (2) ____

10. Perianal skin problems.

☐ No (0) ☐ Yes (3) ____

____ Total NBD score (range 0–47)

NBD score	Bowel Dysfunction
0–6	Very Minor
7–9	Minor
10–13	Moderate
14 or more	Severe